

# PEDIATRIC HISTORY FORM

Dear New Patient,

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: \_\_\_\_\_ S.S.# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Referred by: \_\_\_\_\_

Names of Parents / Gauradians: \_\_\_\_\_

**Purpose For Contacting Us?** \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_ No \_\_\_\_ Yes; Doctors' Names and Prior Treatments: \_\_\_\_\_

Other Health Problems? \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

Ear Infections     Scoliosis     Seizures     Chronic Colds     Headaches  
 Asthma/Allergies     ADHD     Recurring fevers     Colic     Growing/Back Pain  
 Bed wetting     Car Accident     Digestive Problems     Temper Tantrums     Other \_\_\_\_\_

Family History: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care which your child has received there? \_\_\_\_ No \_\_\_\_ Yes

Number of Doses of Antibiotics Your Child has Taken:

During the past six months: \_\_\_\_\_ Total During his / her lifetime: \_\_\_\_\_

Number of Doses of Other Prescription Medications Your Child has Taken:

During the past six months: \_\_\_\_\_ Total During his / her lifetime: \_\_\_\_\_ List: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

## Prenatal History:

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications during pregnancy? \_\_\_\_ No \_\_\_\_ Yes; List: \_\_\_\_\_

Ultrasounds during pregnancy? \_\_\_\_ No \_\_\_\_ Yes; Number: \_\_\_\_\_

Medications during pregnancy / delivery? \_\_\_\_ No \_\_\_\_ Yes; List: \_\_\_\_\_

Cigarette / Alcohol use during pregnancy? \_\_\_\_ No \_\_\_\_ Yes

Location of Birth: \_\_\_\_\_ Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home \_\_\_\_\_ Other: \_\_\_\_\_

Birth Intervention: \_\_\_\_ Forceps \_\_\_\_ Vacuum Extraction

\_\_\_\_ Caesarian Section : emergency or planned (please circle)

Complications during delivery?  No  Yes List: \_\_\_\_\_

Genetic Disorders or Disabilities:  No  Yes List: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_, \_\_\_\_\_

Was delivery within 2 weeks of due date?  Yes  No # of days premature / late: \_\_\_\_\_

### Feeding History:

Breast fed:  No  Yes How long? \_\_\_\_\_

Formula fed:  No  Yes How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to solids at: \_\_\_\_\_ months; Cow's Milk at \_\_\_\_\_ months

Food / Juice Allergies or Intolerances:  No  Yes List: \_\_\_\_\_

### Developmental History:

During the following times your child is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

\_\_\_\_\_ Respond to Sound

\_\_\_\_\_ Cross Crawl

\_\_\_\_\_ Respond to Visual Stimuli

\_\_\_\_\_ Stand Alone

\_\_\_\_\_ Hold Head Up

\_\_\_\_\_ Walk Alone

\_\_\_\_\_ Sit Up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, stairs, etc.) Was this the case with your child?  No  Yes

Is / Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)  No  Yes List: \_\_\_\_\_

Has your child ever been involved in a car accident?  No  Yes List: \_\_\_\_\_

Has your child been seen on an emergency basis?  No  Yes List: \_\_\_\_\_

Other traumas not described above?  No  Yes List: \_\_\_\_\_

Prior surgery:  No  Yes List: \_\_\_\_\_

Menarche:  No  Yes Age: \_\_\_\_\_

### Childhood Diseases:

Chicken Pox N / Y Age \_\_\_\_\_

Mumps N / Y Age \_\_\_\_\_

Rubella N / Y Age \_\_\_\_\_

Whooping Cough N / Y Age \_\_\_\_\_

Rubeola N / Y Age \_\_\_\_\_

Other: \_\_\_\_\_ N / Y Age \_\_\_\_\_

**WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.  
YOUR PARTICIPATION IS VITAL, AND WILL HELP DETERMINE YOUR RESULTS.**

### AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care for my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatment we must require you to read and sign this consent form, stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and rights privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.**

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**Name**

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**Date**

# PROFESSIONAL FEE SCHEDULE

## INITIAL VISIT AND STANDARD VISITS

Consultation	No Charge
Examination	\$60 - \$140
X-rays (per view)	\$55
Office Visit, Adjustment	\$55 - \$70
Extremity Adjustment	\$55
Therapies	\$35

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can.

## PLAN 1: GROUP INSURANCE

If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment, do not pay for maintenance care, and ordinarily are designed and intended to only take care of acute problems. Please understand that insurance companies have cost containment programs to reduce the amount of claims paid even when the patient's care is justified.

## PLAN 2: CASH

Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

## PLAN 3: HEALTH CARE MADE AFFORDABLE (HCMA)

For those patients who qualify, we offer discounted cash agreements on a monthly and block basis. Please ask for details.

## PLAN 4: WORKER'S COMPENSATION INJURY

You need to report your injury to your employer and bring in insurance information. Payment for services is required until insurance information is verified. We will bill the insurance company directly.

## PLAN 5: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

*I have read and understand all of the options available to me.*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_